

STATE OF RHODE ISLAND
Department of Children, Youth and Families

**PHYSICAL, MECHANICAL AND CHEMICAL RESTRAINT AND SECLUSION
REPORT**

Please type:

Child's Name: _____ DOB: _____

Program Name: _____ Admission Date: _____

Number of residents: _____ Staff/client ratio at time of incident: _____

Date of Incident: _____ Time: _____ am/pm

Date of Report: _____ Time: _____ am/pm

Name of staff preparing this report; please print and sign: _____

Names and birthdates of other youth involved or witnesses, if any:

Other Staff on duty (please include names and contact numbers for any staff who were involved or who witnessed the incident):

Required staff to client ratio: _____ Actual staff to client ratio: _____

Type of Intervention (please check all that apply)

☐ Physical Restraint Model: _____

☐ Seclusion ☐ Mechanical Restraint

☐ Chemical Restraint

If Chemical, was the restraint ordered by a physician?

☐ Yes

☐ No

Name of physician _____

Describe child's activity and conduct prior to the incident, including any staff attempts to redirect behavior or interventions attempted to avoid the incident.

Describe the circumstances necessitating the restraint. Was the child a danger to self or others?

Explain any less restrictive interventions that were attempted and why they were ineffective, or why such techniques would have been inappropriate.

Provide details of all actions during the restraint, including the child's behavior (attach additional sheets if necessary).

Duration of Restraint: start: _____ AM/PM end: _____ AM/PM

Monitoring:

15 Minutes

Time/Name _____ / _____ Mental status _____ Behavior _____

30 Minutes

Time/Name _____ / _____ Mental status _____ Behavior _____

45 Minutes

Time/Name _____ / _____ Mental status _____ Behavior _____

59 Minutes

Time/Name _____/_____Mental status _____Behavior _____

Summarize debriefing discussion with the child, including child's views and feelings.

Describe any injuries to the parties, including any medical intervention. What was the child's response when asked if he or she was injured? Was any injury observed? How was the injury incurred?

Describe any changes implemented in child's treatment plan as a result of this incident.

List DCYF personnel notified of any restraint or seclusion that results in injury to a child:

NOTE: Serious physical injury or death resulting from use of restraint or seclusion must be reported immediately to the DCYF Director and, during non-standard business hours (weekends and holidays and weekdays from 4:00 PM to 8:30 AM), to the DCYF Child Protective Services Hotline.

Please print and sign name and title:

Supervisor _____ Date _____

Director _____ Date _____

For DCYF use only

Reviewed by _____ Date _____

Name and title